

## CORRESPONDENCE

sium, 23 mg per dl). Appropriate therapy reversed this tumor lysis syndrome. The patient entered second remission.

About a month later the patient relapsed in spite of maintenance chemotherapy. She proved resistant to subsequent chemotherapy with cyclophosphamide, cytosine arabinoside, vincristine, prednisone and 1-asparaginase, although the aggressive proliferative aspects of the leukemia to date have been controlled by this therapy.

The blasts on Wright-Giemsa morphology ranged from small L-1 types with a high nuclear cytoplasmic ratio, mature chromatin and indistinct nucleoli, to forms that almost approached mature lymphocytes. Cytochemical stains for AML (Sudan, peroxidase and chloracetate esterase) were negative. Periodic acid-Schiff (PAS) stain was negative for block positivity. Lipase stain showed punctate positivity in some forms, which is a characteristic seen with some cases of ALL. Terminal deoxynucleotidyl transferase by immunofluorescent method was negative twice, and by the biochemical method done twice on both blood and bone marrow (at City of Hope National Medical Center, Los Angeles) also negative—in a blood specimen on January 2, the protein value was 1.1  $\mu$ U per mg (normal less than 5.2  $\mu$ U per mg); in a blood specimen on April 2, the protein value was 4.0  $\mu$ U per mg and in a bone marrow specimen on April 2, there was a 7.4  $\mu$ U per mg of protein value (normal less than 22.6  $\mu$ U per mg). Lymphocyte marker studies were done on several occasions and showed E rosettes of 88 percent and of 82 percent, and surface immunoglobulin-bearing cells of 10 percent and 5 percent. An anti-theta antigen study using monoclonal mouse anti-sera showed 77 percent, an anti-Ia 12 percent and an anti-common ALL antigen 0 percent (last three tests carried out by Dr. Richard Gatti's laboratory, Cedars-Sinai Medical Center).

Variants of T-ALL exist. A recent report by Richie and co-workers<sup>3</sup> described the case of a patient with T-ALL who was anti-T positive but E rosette negative. The authors hypothesized that in their case the leukemic cells represented an early stage of T cell maturation. In our case we feel that the T cells may represent a late stage in maturation where TdT activity is lost. The mature nature of the cells may account for the immediate and dramatic response to vincristine and prednisone on two occasions. We suggest that this

subset of T-ALL should be searched for to anticipate a rapid response and a tumor lysis syndrome.

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## REFERENCES

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3. Richie ER, Sullivan MP, van Eys J: A unique surface marker profile in T-cell acute lymphocytic leukemia. *Blood* 55:702-705, Apr 1980

## The Importance of Making Precise Medical Records in the 1980's

TO THE EDITOR: While serving as a prosecution attorney for California's Board of Medical Quality Assurance, I noted the problems physicians had in persuading the trier of fact as to the credibility of their perception of the events or their memories of them. During the last three years, I have defended physicians before the Board, and have been involved in defense malpractice cases. It is evident to me that physicians continue to fail to realize the importance of keeping detailed medical records.

A physician may treat patients for years without much thought to his record keeping. Then one day he is sued, and he discovers that his records do not substantiate the professional decisions he made at the time. He is left to the recollection of such events, some happening many years before the lawsuit is filed. Before he finally is called to testify, additional years may intervene to cloud his memory. It then becomes a matter of credibility. A physician who sees many patients a day, over a period of years, may have a difficult time convincing anyone that he can recall, without precise medical records, how he treated one particular patient.

By carefully documenting all aspects of patient care and treatment, a physician will not be limited to his memory, should he ever be required to defend his professional decisions. Detailed record keeping should not only refresh his memory of a particular case, but also bolster his credibility in court, should a dispute arise.

Some physicians may balk at keeping detailed medical records, claiming it interferes with or takes time away from the practice of medicine. This position fails to accept the realities of practicing medicine in the 1980's. Patients expect more from physicians today than ever before. Many

patients demand perfection from their physicians. Our consumer-oriented society would seem to require that if a patient pays a physician a certain amount of money for medical treatment, the results should be "instant good health." If this is not obtained, the patient may feel he has been cheated, financially as well as medically, and may seek retribution in the courts.

Maintaining careful records need not interfere with the practice of medicine. With modern mini-tape recorders, no physician needs to spend hours compiling records. After conversations with each patient, he can spend a few minutes recording the pertinent information, which later can be transcribed into the patient's chart. An additional benefit of such a system is that a physician is afforded a second opportunity to determine whether the essentials are correctly recorded, and to reconsider the professional judgments he has recently made. The *recording, transcribing and proofreading* system can also assist a physician in properly monitoring and following the progress of a patient. For example, a physician may request a variety of laboratory or clinical tests to be carried out, or recommend a consultation with another physician. Because many patients may not fully understand the nature of their condition, they may not realize the importance of such tests or second opinions. By failing to follow the physician's instructions, or by postponing appointments or tests, the patient may be contributing to his own decline in health. In such cases, a review of the records gives the physician a further opportunity to recall the patient's condition, and see whether or not the patient has returned for recommended tests, and whether the results of any second opinion have been received. This reading of the transcribed notes will alert the physician to these trouble spots, and he can take steps to see that the patient is advised of the importance of following through with recommended treatment. A note can be made in the chart that the patient was contacted for this purpose.

In administering or prescribing medications, the rules of informed consent must apply. The physician must explain to the patient the purpose of the medications, and must record this information as well as the medical indications that are the basis for his decision to medicate. The patient must be informed of the possible undesirable effects of the particular drug and whether other medications or alcohol may be taken simultaneously. The patient should be told what side effects or allergic reac-

tions should be reported to the physician. All of these elements of informed consent should be documented in the patient's chart.

Also helpful is a brief dialogue between the physician and patient, in which the physician assures himself that the patient understands the information related, whether about drugs or any other aspect of medical treatment, and whether treatment is approved by the patient or postponed by the patient. Finally, detailed records of these aspects of patient care and treatment are essential. The old saying "An ounce of prevention is worth a pound of cure" has more than one meaning in contemporary medicine. A little extra time and effort in a physician's office today may well prevent, or at least mitigate, a major calamity in the courts at some future time.

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## Subacute Laetrile Intoxication

TO THE EDITOR: Laetrile, despite a federal ban and a paucity of sound evidence in the efficacious treatment of cancer, is legal in many states, most recently in California (January 1981). There are several reports<sup>1-4</sup> of toxicity and death due to overdose with Laetrile. However, this case presents a patient who was successfully treated for documented cyanide poisoning with Laetrile taken in "therapeutic" dosages. Laetrile's increasing acceptance by lay persons, a segment of the medical community and state legislators mandates clinical recognition of its toxicity.

### Report of a Case

A 45-year-old white woman presented to the emergency department with onset over the preceding two hours of progressive dyspnea and agitation. She had had a left mastectomy in July 1978 for a documented adenocarcinoma; and a left thoracentesis had been required in November 1980 for drainage of a pleural effusion caused by the malignancy. A bone scan done during that hospital stay showed positive isotope uptake in multiple anterior ribs. The patient's medications on present admission included vitamin A (once daily), yeast, multivitamins (once daily), occasional aspirin tablets for rib pain, tamoxifen (10 mg orally twice a day) and Laetrile (10 ml injections [3 grams] intravenously, three times a week and 1 gram orally, twice a day, on the days which she was not receiving it intravenously). The